

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6529

CERTIFICATE OF DEATH

06517
282

Reg. Dist. No.

1. PLACE OF DEATH

o. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Leonardtown

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

Maryland

b. COUNTY

St. Mary's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Mechanicsville

d. STREET ADDRESS

none

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF DECEASED (Type or print)

First
PaulineMiddle
ReginaLast
BARBER

4. DATE OF DEATH

Month
JuneDay
22
Year
1956

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

August 23, 1887

9. AGE (In years last birthday)

69 yrs.

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months
DaysHours
Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

School Teacher

10b. KIND OF BUSINESS OR INDUSTRY

State

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Samuel ADAMS

14. MOTHER'S MAIDEN NAME

Jane A. McGregor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Ninian P. Barber Jr. Mechanicsville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

381X

DUE TO

CVA

INTERVAL BETWEEN

ONSET AND DEATH

30 hrs

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

DUE TO

hypertension

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While Not while
of work of work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from March 1, 1956 to July 4, 1956 that I last saw the deceased
alive on June 21, 1956, and that death occurred at 11 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Leona Bembe

M.D.

PHYSICIAN'S
NAME (Type)

Dr. J. Roy Guyther

Mechanicsville, Maryland

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

June 25, 1956

22c. NAME OF CEMETERY OR CREMATORI

St. Joseph's Cem.

22d. LOCATION (City, town, or county)

(State)

Morganza, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

P. B. Robinson

ADDRESS

Leonardtown, Md.

24a. REC'D BY REGISTRAR

DATE 6/25/56

24b. REGISTRAR'S SIGNATURE

Leonard Hauser

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

CERTIFICATE OF DEATH

AV
not yet sent

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3 June

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282

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

6530

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY St Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY St Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtown		c. LENGTH OF STAY IN 1b 3 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clements	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Augustus	Middle Leroy	Last Berry
4. DATE OF DEATH	Month June	Day 17,	Year 19 56
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 25, 1948
9. AGE (In years last birthday) 7 yrs.	10. IF UNDER 1 YEAR 5 Months	11. IF UNDER 24 HRS. 23 Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Agustus William Berry	14. MOTHER'S MAIDEN NAME Mary Madalene Thomas	Address Agustus W. Berry Clements, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Showering DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Roy Guyther</i>	DATE SIGNED <i>June 18 56</i>		
EXAMINER'S NAME (Type) Roy Guyther M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/20/56	22c. NAME OF CEMETERY OR CREMATORIUM St Joseph	22d. LOCATION (City, town, or county) (State) Morganza, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly Leonardtown, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE 6/19/56	24b. REGISTRAR'S SIGNATURE <i>Alan L. Houser</i>

OPTIONAL FORM NO. 10
MAY 1962 EDITION
GSA GEN. REG. NO. 27

BUREAU U. S.

JUN 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86519

Reg. Dist. No. 282

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtown		c. LENGTH OF STAY IN 1b 3 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
f. FIRST NAME Christene MIDDLE NAME Elane LAST NAME Berry		g. DATE OF DEATH June 17, 1956	
h. SEX Female		i. COLOR OR RACE Colored	
j. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		k. DATE OF BIRTH September 11, 47	
l. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		l. 10b. KIND OF BUSINESS OR INDUSTRY	
l. 11. BIRTHPLACE (State or foreign country) Maryland		l. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
m. 13. FATHER'S NAME Agustus William Berry		n. 14. MOTHER'S MAIDEN NAME Mary Madalene Thomas	
o. 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		p. 16. SOCIAL SECURITY NO.	
q. 17. INFORMANT Agustus W. Berry Clements, Md.		r. ADDRESS	
s. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
t. PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Resounding u. DUE TO v. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) w. DUE TO x. (c)			
y. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
z. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
aa. 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		bb. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
cc. 20c. TIME OF INJURY Hour a. m. 19 p. m.		dd. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
ee. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		ff. 20f. (City or town) Morganza (County) Maryland (State)	
gg. 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>			
hh. ACTUAL SIGNATURE Roy Guyther ii. EXAMINER'S NAME (Type) Roy Guyther M.D.		jj. DATE SIGNED June 18 1956 kk. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ll. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> mm. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
nn. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		nn. 22b. DATE THEREOF 6/20/56	
nn. 22c. NAME OF CEMETERY OR CREMATORIAL ST Joseph's		nn. 22d. LOCATION (City, town, or county) Morganza , (State) Maryland	
nn. 23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly ADDRESS Leonardtown, Md.		nn. 24a. REC'D BY REGISTRAR nn. 24b. REGISTRAR'S SIGNATURE nn. 24c. DATE 6/19/56 Glen D. Hauser	

DEPARTMENT OF STATE - HAITI - MARCH 1956

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BUREAU V. S.

APR 20 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 7. Filing 6199 6-26-56 et
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

186520

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY <u>St Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Leonardtown</u>		c. LENGTH OF STAY IN lb <u>3 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	

3. NAME OF DECEASED (Type or print)	First <u>Madeline</u>	Middle	Last <u>Berry</u>	4. DATE OF DEATH	Month <u>June</u>	Day <u>17</u>	Year <u>1956</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8, 1928</u>	9. AGE (In years last birthday) <u>28</u> yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	11. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13. FATHER'S NAME <u>Unknown</u>	14. MOTHER'S MAIDEN NAME <u>Annie Thomas</u>	Address
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>929.9</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Agustus W. Berry Clements, Maryland</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	
DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	
DUE TO	
(c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. <input type="checkbox"/> p. m. <input type="checkbox"/> 19	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
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ACTUAL SIGNATURE <u>J. Roy Guyther</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <u>June 17, 1956</u>
EXAMINER'S NAME (Type) <u>J. Roy Guyther</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (if city) <u>Burial</u>	22b. DATE THEREOF <u>6/20/56</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>St Joseph</u>	22d. LOCATION (City, town, or county) (State) <u>Morganza</u> Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Mattingly Leonardtown, Md.</u>	ADDRESS	24a. REC'D BY REGISTRAR DATE <u>6/19/56</u>	24b. REGISTRAR'S SIGNATURE <u>Glen D. Hauser</u>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WISCONSIN STATE DEPARTMENT OF HEALTH - SIGHTINGS 19

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 20 1956

RECEIVED

86521

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6533 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 282

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY St Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtown		c. LENGTH OF STAY IN 1b 3 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle L. Last Berry		4. DATE OF DEATH Month June Day 17, Year 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1949
9. AGE (In years less birthday) 6 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Agustus William Berry		14. MOTHER'S MAIDEN NAME Mary Madalene Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Address Agustus W. Berry Clements Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO 929.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>J. Roy Guyther</i>	DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) Roy Guyther M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/20/56	22c. NAME OF CEMETERY OR CREMATORIAL St Joseph's	22d. LOCATION (City, town, or county) (State) Morganza, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly Leonardtown, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE 6/19/56	24b. REGISTRAR'S SIGNATURE <i>Glen L. Hauser</i>

WISCONSIN STATE BOARD OF EXAMINERS OF MEDICAL EXAMINERS' CERTIFICATE OF DEATH

BUREAU V. 2

UN 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06522

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 39 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. MARY'S HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MECHANICSVILLE	
3. NAME OF DECEASED (Type or print) LYDIA		First A.	Middle BOND
4. DATE OF DEATH JUNE 6 1956	Month JUNE	Day 6	Year 1956
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 6 1897
9. AGE (In years lost birthday) 58 yrs.	10. IF UNDER 1 YEAR 8 Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FRANK L. BOND		14. MOTHER'S MAIDEN NAME M. DAVIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. HAYDEN B. BOND, MECHANICSVILLE MD.	
17. INFORMANT HAYDEN B. BOND, MECHANICSVILLE MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Carcinoma of breast with generalized metastasis 192			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1, 1956 , to June 6, 1956 , that I last saw the deceased alive on June 5, 1956 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Md. DATE SIGNED 6/6/56			
ACTUAL SIGNATURE ROY J. GUYTHER M.D.			
PHYSICIAN'S NAME (Type) ROY J. GUYTHER		MECHANICSVILLE MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/8/56	
22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES J. MATTINGLY		24a. REC'D BY REGISTRAR DATE 6/7/56	
24b. REGISTRAR'S SIGNATURE Gloria L. Hauser			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16523
282

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY St Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY St Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtown		c. LENGTH OF STAY IN lb 3 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Gladis	Middle Virginia	Last Brown
4. DATE OF DEATH	Month June	Day 17,	Year 19 56
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> March 27, 1943	9. AGE (In years (at birthday) yrs. 13) IF UNDER 1 YEAR Months 2 Days 21 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary Madalene Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Agustus W. Berry Clements, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO 929.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Roy Guyther</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>June 18, 1956</i>
EXAMINER'S NAME (Type) Roy Guyther M.D.	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 6/20/56 22c. NAME OF CEMETERY OR CREMATORIUM St Joseph's 22d. LOCATION (City, town, or county) Morganza, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly Leonardtown, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>6/19/56</i>	24b. REGISTRAR'S SIGNATURE Glen D. Hauser

DEPARTMENT OF STATE, WASHINGTON, D. C. 20520
RECORDED AND INDEXED
MAY 12, 1968

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ST. MARYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREAT MILLS		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CALLAWAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RURAL		d. STREET ADDRESS RURAL	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HELEN		First MIGNONETTE	Middle BRYANT
4. DATE OF DEATH JUNE 8 1956		5. SEX FEMALE	6. COLOR OR RACE WHITE
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 17, 1906	
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE R. DEMENT		14. MOTHER'S MAIDEN NAME ALETHA M. PRICE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Address EMORY M. BRYANT - CALLAWAY, MARYLAND.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 <i>Coronary occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic cholecystitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> al work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 28, 1956 , to June 8, 1956 , that I last saw the deceased alive on June 8, 1956 , and that death occurred at 9:10 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Great Mills, Md. DATE SIGNED 6/14/56	
ACTUAL SIGNATURE <i>P. B. Bean</i>		PHYSICIAN'S NAME (Type) M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/11/56	22c. NAME OF CEMETERY OR CREMATORIAL POPLAR HILL CEMETERY
22d. LOCATION (City, town, or county) VALLEY LEE, MARYLAND		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. B. Johnson - LEONARDTOWN, Md.</i>		24a. REC'D BY REGISTRAR DATE 6/10/56	24b. REGISTRAR'S SIGNATURE <i>Open for signature</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be referred to by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

116525

6537

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Edward	Middle Luther	Last Burroughs	4. DATE OF DEATH	Month June	Day 22, 1956
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 30, 1864	9. AGE (In years birthday) 91 yrs.	10. IF UNDER 1 YEAR 7 Months	11. IF UNDER 24 HRS. 23 Hours	12. Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Thomas Burroughs		14. MOTHER'S MAIDEN NAME Mary Margaret Bond					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT E.Ray Burroughs		Address Mechanicsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cancer of rectum				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Mechanicsville	(County) Md. (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Leon A. Benke</i>						ADDRESS (Street, city or town, state) Mechanicsville, Md. DATE SIGNED	
PHYSICIAN'S NAME (Type) J. Roy Guyther M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/56		22c. NAME OF CEMETERY OR CREMATORIAL All Faith		22d. LOCATION (City, town, or county) Charlotte Hall, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly Leonardtown, Md.		ADDRESS		24a. REC'D. BY REGISTRAR DATE 6/25/56		24b. REGISTRAR'S SIGNATURE Alfred S. Hauser	

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JUN 27 1956

1. PLACE OF DEATH a. COUNTY ST. MARY'S			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGE		c. LENGTH OF STAY IN 1b 29 YRS.		b. COUNTY ST. MARY'S			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. INIGOES				
3. NAME OF DECEASED (Type or print) WILLIAM			d. STREET ADDRESS				
First THOMAS	Middle COULTER	Last JUNE	4. DATE OF DEATH 1867	Month JUNE	Day 12		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 22 1863	9. AGE (In years last birthday) 88 02	10. IF UNDER 1 YEAR Months 10	11. IF UNDER 24 HRS. Days 10	Year Hours 19 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10b. KIND OF BUSINESS OR INDUSTRY PLUMBING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME ANDREW COULTER			14. MOTHER'S MAIDEN NAME SARAH MCDONALD			Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT STANLEY RALEY		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized arteriosclerosis (c)	
						INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) ST. INIGOES	(County) MD.	(State) MD.
21. I certify that I attended the deceased from May 10, 1956 , to June 12, 1956 , that I last saw the deceased alive on June 9, 1956 , and that death occurred at 4 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ADDRESS						DATE SIGNED 6/13/56	
ACTUAL SIGNATURE <i>P. J. BEAN</i>		M.D.					
PHYSICIAN'S NAME (Type) P. J. BEAN M.D.		GREAT MILLS MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/16/1956		22c. NAME OF CEMETERY OR CREMATORIAL ST. MICHAEL		22d. LOCATION (City, town, or county) RIDGE	
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES J. MATTINGLY		ADDRESS LEONARDTOWN MD.		24a. REC'D BY REGISTRAR 6/13/56		24b. REGISTRAR'S SIGNATURE <i>W. J. O'Reilly</i>	

STATE OF HAWAII - DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

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JUN 14 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6539 CERTIFICATE OF DEATH 67569
Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>St. Mary's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LEONARDTOWN</i>		c. LENGTH OF STAY IN 1b <i>2 HRS</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>OAKVILLE</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>ST. MARY'S HOSPITAL</i>						e. IS RESIDENCE ON A FARM? / YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>NEWBORN Baby</i>		First <i>Baby</i>	Middle <i>Ford</i>	Last <i>JUNE</i>	Month <i>23</i>	Day <i>1956</i>	Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 23 '56</i>	9. AGE (In years lost birthday) <i>2 MRS</i>	10. IF UNDER 1 YEAR Months <i>2</i>	11. IF UNDER 24 HRS. Days <i>2</i>	12. IF UNDER 24 HRS. Hours <i>2</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Aloysius DICKERSON</i>		14. MOTHER'S MAIDEN NAME <i>BARBARA ANN FORD</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>MOTHER</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>762.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
UNKNOWN - POSSIBLY ASPHYXIA DUE TO MUCOS INTERVAL BETWEEN ONSET AND DEATH <i>2 HRS</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>PREMATURITY</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>—</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State) <i>—</i>	
21. I certify that I attended the deceased from <i>June 23, 1956</i> , to <i>June 23, 1956</i> , that I last saw the deceased alive on <i>June 23, 1956</i> , and that death occurred at <i>9 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. Roy Guyther</i> PHYSICIAN'S NAME (Type) <i>J. Roy Guyther, M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>—</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Aloysius</i>		22d. LOCATION (City, town, or county) (State) <i>Leonardtown, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clarke Mattingly, Leonardtown, Md.</i>		ADDRESS <i>1000 17th St.</i>		24a. REC'D BY REGISTRAR DATE <i>7/16/56</i>		24b. REGISTRAR'S SIGNATURE <i>Glenn D. Hauser</i>	

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REGELY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6540

CERTIFICATE OF DEATH

16527
281
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ST. MARYS MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LEONARDTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SCOTLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 78 ST. MARYS HOSPITAL		d. STREET ADDRESS RURAL	
3. NAME OF DECEASED (Type or print) MARY		First PEARL	Middle GIBSON
4. DATE OF DEATH JUNE 17	Month Year 1956		
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1888
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Jack Bennett		14. MOTHER'S MAIDEN NAME Anna Brooks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -----	17. INFORMANT Alexander Cullison - Scotland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 weeks Firebrail hemorrhage	
(b) DUE TO Generalized arterio-sclerosis		10 years	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 1, 1956, to June 17, 1956, that I last saw the deceased alive on June 16, 1956, and that death occurred at 3 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) GREAT MILLS, MARYLAND		DATE SIGNED 6/17/56	
ACTUAL SIGNATURE P. J. BEAN		PHYSICIAN'S NAME (Type) ST. LUKE'S CEMETERY	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-20-56	22c. NAME OF CEMETERY OR CREMATORIUM ST. LUKE'S CEMETERY
22d. LOCATION (City, town, or county) SCOTLAND, MARYLAND		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE OB Robinson		24a. REC'D BY REGISTRAR DATE 6/18/56	24b. REGISTRAR'S SIGNATURE Local Registration

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BT 69007148-11130 TO THE 19490 STATE OF ALABAMA

BUREAU V. 2

UN 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

116528

6541

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SCOTLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. MARYS HOSPITAL		d. STREET ADDRESS RURAL	
3. NAME OF DECEASED (Type or print) REAVA		First MIDDLE IRENE	Last GOUGH
4. DATE OF DEATH JUNE 3, 1956		Month JUNE	Day 3
5. SEX FEMALE		6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH 30 JAN. 1928
8. IF UNDER 1 YEAR Months Days		9. AGE (In years lost birthday) 28 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CALVERT BARNES	
14. MOTHER'S MAIDEN NAME INEZ BISCOE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 212-24-3878		17. INFORMANT ROBERT GOUGH - SCOTLAND, MARYLAND.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0		DUE TO and body	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) There was a fire which forced onto her clothing	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>June 1, 1956</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) home
20f. (City or town) Scotland		(County) <i>St. Marys</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>June 1, 1956</i> to <i>June 3, 1956</i> that I last saw the deceased alive on <i>June 3, 1956</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) GREAT MILLS, MARYLAND.	
ACTUAL SIGNATURE <i>P. J. Bean</i>		DATE SIGNED <i>June 4/56</i>	
PHYSICIAN'S NAME (Type) P. J. BEAN, MD		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/6/56	22c. NAME OF CEMETERY OR CREMATORIUM ST. LUKES CEMETERY
22d. LOCATION (City, town, or county) SCOTLAND, MARYLAND		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. B. Robinson</i>		24a. RECEIVED BY REGISTRAR DATE <i>June 6/56</i>	24b. REGISTRAR'S SIGNATURE <i>P. B. Robinson</i>
ADDRESS * LEONARDTOWN, MD.		FEDERAL DEPARTMENT	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of her death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 390 ATLAS-FLASH 30 TRANSISTORS STATE GRAY/TRAN

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JUN 6 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, (See birth Cert.)

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b Leonardtown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		d. STREET ADDRESS Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Edward GRAVES		First	Middle	Last	4. DATE OF DEATH Month June	Day 24	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 1916	9. AGE (In years lost birthday) 40 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. HOURS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis B. GRAVES				14. MOTHER'S MAIDEN NAME Eva McGINLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1934 - 1936		17. INFORMANT Louis B. GRAVES Jr.		Address Leonardtown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 322.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH malignant, chronic arteriosclerosis Hypertension							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Leonardtown	(County) St. Mary's	(State) Md.
21. I certify that I attended the deceased from June 23, 1956 to June 29, 1956 , that I last saw the deceased alive on June 29, 1956 , and that death occurred at 12 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Leonardtown, Maryland							
ACTUAL SIGNATURE Dr. M. Barbarich	DATE SIGNED 6/25/56						
PHYSICIAN'S NAME (Type) Dr. M. Barbarich	Leonardtown, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 27, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.	22d. LOCATION (City, town, or county) Arlington, Virginia				
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson	ADDRESS Leonardtown, Md.	24a. REC'D BY REGISTRAR 6/25/56	24b. REGISTRAR'S SIGNATURE Glenda P. Hayes				

BT BROWNSTAB-RT-1439 TO THE TRADE STATES OF MARYLAND

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 116530/82

1. PLACE OF DEATH o. COUNTY St Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mechanicsville		c. LENGTH OF STAY IN 1b Life				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mechanicsville				
3. NAME OF DECEASED (Type or print) Robert Theodore		First Middle Last Herbert	4. DATE OF DEATH Month June Day 10, Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 7, 1879			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Benjamin Herbert		14. MOTHER'S MAIDEN NAME Elizabeth Dean				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mary Ozema Herbert Mechanicsville, Md.			
Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DEGENERATIVE HEART DISEASE (CORONARY</u> 420.1 DUE TO <u>SCLEROSIS)</u>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIO-SCLEROSIS</u> DUE TO (c)						
INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u>						
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) _____				
20c. TIME OF INJURY Month, Doy, Year Hour o. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____	(County) _____	(State) _____
21. I certify that I attended the deceased from <u>SEPTEMBER 1948</u> , to <u>JUNE 10, 1956</u> , that I last saw the deceased alive on <u>JUNE 8, 1956</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hugesville, Md. DATE SIGNED 6/11/56						
ACTUAL SIGNATURE <u>John H. Griffin</u>		M.D.				
PHYSICIAN'S NAME (Type) John H. Griffin M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/56	22c. NAME OF CEMETERY OR CREMATORIUM St Mary's	22d. LOCATION (City, town, or county) Bryantown, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 6/11/56	24b. REGISTRAR'S SIGNATURE <u>Dean R. Hauser</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01-3890118-071AB 30 JUL 1978 11472 ORANGE

JUN 12 1956

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MAY 12 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66531

Reg. Dist. No. 281

6544 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5-8 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
ST. MARY'S MARYLAND		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		b. COUNTY	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First PAUL	Middle HARRISON	Last MASON
4. DATE OF DEATH	JUNE 29		Year 1956
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
MALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MAY 26 1889
9. AGE (In years last birthday)	67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HAMPTON MASON		14. MOTHER'S MAIDEN NAME LAURA ANN COALE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220 34 8327 17. INFORMANT MRS. ALBERTA MASON LEONARDTOWN MD.	
Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> INTERVAL BETWEEN ONSET AND DEATH <i>420.1</i> <i>immediate</i> DUE TO Conditions, if any, which gave rise to immediate cause (a) (b) (c), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H. J. Bean, M.D.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>June 30 1956</i>
EXAMINER'S NAME (Type) P. J. BEAN M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/2/1956	22c. NAME OF CEMETERY OR CREMATORIAL OUR LADY'S	22d. LOCATION (City, town, or county) MEDLEY'S NECK (State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY	ADDRESS LEONARDTOWN, MD	24a. REC'D BY REGISTRAR JAN 30 1956	24b. REGISTRAR'S SIGNATURE W. CLARKE MATTINGLEY

RECEIVED - EXAMINED - SERIALIZED - INDEXED - FILED
DEPARTMENT OF STATE - WASH. 25, D. C.

BUREAU V. S.

JUL 5 1956

Reed - [initials]

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6545

CERTIFICATE OF DEATH

86532

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY ST. MARYS		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ST. MARYS		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b ST. MARYS HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COMPTON		d. STREET ADDRESS RURAL		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. MARYS HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) WILLIAM		First	Middle	Last	4. DATE OF DEATH JUNE 8 1956	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1870	9. AGE (In years last birthday) 86	10. IF UNDER 1 YEAR Months 86	11. IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JAMES MATHews			14. MOTHER'S MAIDEN NAME MARTHA ANTLE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Hospital Records - Leonardtown, Md.		
Unk.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO cause (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonitis, left lung.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state) Mechanicsville						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 1, 1956 , to June 8, 1956 , that I last saw the deceased alive on June 7, 1956 , and that death occurred at 6 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Roy Guy Guther		ADDRESS (Street, city or town, state) Mechanicsville						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/12/56		22c. NAME OF CEMETERY OR CREMATORIAL Saint Paul Cemetery		22d. LOCATION (City, town, or county) Leonardtown, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE J. B. Robinson		ADDRESS Leonardtown, Md.		24a. REC'D BY REGISTRAR Glenn D. House		24b. REGISTRAR'S SIGNATURE Glenn D. House		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)
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A34
B3

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 15 1956

RECEIVED

1. ROA GARDNER, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **106533**
281

6546

1. PLACE OF DEATH a. COUNTY St Mary's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 3 hrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Prince George	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St Mary's Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill		d. STREET ADDRESS 4969 Kepplar Road S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Raymond A. McDonald		First	Middle	Last	4. DATE OF DEATH June 13, 1956	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1900	9. AGE (In years 55 <small>lost birthday</small> yrs.)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transportation Supervisor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel McDonald		14. MOTHER'S MAIDEN NAME Ella Chester							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, no		16. SOCIAL SECURITY NO.		17. INFORMANT C.R. Bradshaw 1226 Saratoga Ave. N.E.		Address Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Coronary occlusion (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 hours			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Washington, D.C.		(County) D.C. (State) D.C.	
21. I certify that I attended the deceased from June 13, 1956 , to June 13, 1956 , that I last saw the deceased alive on June 13, 1956 , and that death occurred at 6:57 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Great Mills Md		DATE SIGNED 6/13/56			
ACTUAL SIGNATURE P.J. Bear M.D.									
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-16-56		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet		22d. LOCATION (City, town, or county) Washington, D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		ADDRESS							
		24a. REC'D BY REGISTRAR 6/13/56							
		24b. REGISTRAR'S SIGNATURE P.J. Bear, M.D.							

CERTIFICATE OF DEATH

BUREAU V. S.

MUN 14 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6547

CERTIFICATE OF DEATH

66534
Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First William	Middle Edward	Last McGee	4. DATE OF DEATH June 13, 1956	Month June	Day 13	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH January 19, 1913	9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Days 25	Hours Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Stephen H McGee		14. MOTHER'S MAIDEN NAME Ruth E. Raley						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-16-7692		17. INFORMANT Mrs Thelma McGee Hollywood, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X DUE TO		Hodgkin Disease				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs		
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO								
DUE TO								
DUE TO								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. g. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Mechanicsville, Md.		(County) Hollywood Maryland Mechanicsville
21. I certify that I attended the deceased from <u>July 15, 1956</u> to <u>June 13, 1956</u> that I last saw the deceased alive on <u>June 11, 1956</u> and that death occurred at <u>205</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Roy Guyther</u>								DATE SIGNED <u>June 19, 1956</u>
PHYSICIAN'S NAME (Type) Roy Guyther M.D.								ADDRESS (Street, city or town, state) Mechanicsville, Md.
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/16/56		22c. NAME OF CEMETERY OR CREMATORIAL St. John's		22d. LOCATION (City, town, or county) Hollywood, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly Leonardtown, Md.		ADDRESS Charles J. Mattingly Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 6/19/56		24b. REGISTRAR'S SIGNATURE Frank D. Hauser		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

CERTIFICATE OF DEATH

Date of Birth

Cause of Death

Place of Death

Name of Physician

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Mortuary

Name of Funeral Director

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Mortuary

Name of Funeral Director

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Name of Funeral Director

Name of Cemetery

Name of Funeral Home

Name of Embalmer

Name of Mortuary

Name of Funeral Director

Name of Cemetery

BUREAU OF DEATH

MAY 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6548

CERTIFICATE OF DEATH

86535
282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ST MARYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		b. COUNTY ST. MARYS	
c. LENGTH OF STAY IN 1b 78		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PALMERS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. MARYS HOSPITAL		d. STREET ADDRESS RURAL	
3. NAME OF DECEASED (Type or print) LYDIA		First -----	Middle -----
4. DATE OF DEATH June 16		Month -----	Day Year 1956
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1868
9. AGE (In years lost birthday) 87		10. IF UNDER 1 YEAR Months 87	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Faunce		14. MOTHER'S MAIDEN NAME Emma Selby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Address Mary E. Palmer - Palmers, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure	
782-4		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Pneumonia - senile	
DUE TO (b)		DUE TO (c) open reduction left hip	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-29-56 to 6-16 1956 that I last saw the deceased alive on 6-15-56 , 1956, and that death occurred at 8A M, from the causes and on the date stated above. ACTUAL SIGNATURE Michael Barbarich M.D.		ADDRESS (Street, city or town, state) Leonardtown, Md. DATE SIGNED Leonardtown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/19/56	
22c. NAME OF CEMETERY OR CREMATORIAL All Saints Cemetery		22d. LOCATION (City, town, or county) Oakley, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. D. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 6/18/56	
		24b. REGISTRAR'S SIGNATURE Glenda D. Hauser	

MARYLAND STATE DEPARTMENT OF HEALTH-CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 19 1956

PREGELIVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. *1*
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6549

CERTIFICATE OF DEATH

06536

Reg. Dist. No.

281

1. PLACE OF DEATH a. COUNTY Saint Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural California, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 512 25th. St. South, Arlington, Va.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Station Hospital, USNAS Patuxent River, Maryland		d. STREET ADDRESS Lexington, Maryland	
3. NAME OF DECEASED (Type or print) Russell		First Lott	Middle SEWELL
4. DATE OF DEATH June 1 1956		Last SEWELL	Month Day Year 1 19 56
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Pilot, U.S.Navy	11. BIRTHPLACE (State or foreign country) Alabama
13. FATHER'S NAME John Will SEWELL		14. MOTHER'S MAIDEN NAME Frances LOTT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 7-28-41	17. INFORMANT U. S. Naval Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Basal Skull Fracture		INTERVAL BETWEEN ONSET AND DEATH 15 Min.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Multiple depressed fracture ribs, rt. side with probable lung laceration			
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple depressed fracture ribs, rt. side with probable lung laceration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident	
20c. TIME OF INJURY Hour 6:20 Month June Day 1 Year 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
21. I certify that I attended the deceased from _____ to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 6:30 P.M., from the causes and on the date stated above.		20f. (City or town) Near California, St. Mary's	
ACTUAL SIGNATURE <i>C. W. Freeby</i>		ADDRESS (Street, city or town, state) M.D. Station Hospital, USNAS	
PHYSICIAN'S NAME (Type) C. W. FREEBY, LT MC USNR		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/5/56	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National
22d. LOCATION (City, town, or county) Arlington, Va.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>O. B. Robinson</i>		24a. REGD BY REGISTRAR DATE June 6/6	24b. REGISTRAR'S SIGNATURE <i>O. B. Robinson</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66537

282

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

ST. MARY'S

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

LEXINGTON PARK

c. LENGTH OF STAY IN 1b

LIFE

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MARYLAND

b. COUNTY

ST. MARY'S

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

LEXINGTON PARK

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

JOSEPH

IGNATIUS

THOMAS

DEATH

JUNE 11

1956

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
lost birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MALE

COLORED

WIDOWED DIVORCED

JAN. 14 1883

Months

Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

FARMER

FARMING

MARYLAND

U.S.A.

13. FATHER'S NAME

SAMUEL THOMAS

14. MOTHER'S MAIDEN NAME

EMILY CAROLL

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

McDOWELL THOMAS CALIFORNIA

MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Chronic myocarditis

INTERVAL BETWEEN
ONSET AND DEATH

1 year

449X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

Hypertension

10 years

DUE TO

Generalized arteriolosclerosis

10 years

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. g. 19
p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from July 1, 1955, to June 11, 1956 that I last saw the deceased
alive on June 11, 1956, and that death occurred at 6 P. M. from the causes and on the date stated above.ACTUAL
SIGNATURE

John H. Patrick

M.D.

ADDRESS (Street, city or town, state)
325 Midway Drive, Lexington Park, Md.

DATE SIGNED

PHYSICIAN'S
NAME (Type)

W. H. PATRICK

M.D.

CALIFORNIA

MARYLAND

22a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF
6/14/195622c. NAME OF CEMETERY OR CREMATORIUM
HOLY FACE22d. LOCATION (City, town, or county)
GREAT MILLS(State)
MD.

23. FUNERAL DIRECTOR'S SIGNATURE

CHARLES J. MATTINGLY

ADDRESS

LEONARDTOWN MD.

24a. REG'D BY REGISTRAR

DATE

6/14/56

24b. REGISTRAR'S SIGNATURE

John H. Slawson

WISCONSIN STATE DEPARTMENT OF HEALTH—CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

BUREAU V.

JUN 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6551 CERTIFICATE OF DEATH

Reg. Dist. No. 282

1

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Florida		b. COUNTY Alachua					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		c. LENGTH OF STAY IN 1b 5 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gainesville		48 x 3					
d. NAME OF HOSPITAL (If in hospital give first address) OR INSTITUTION Station Hospital, USNAS, Patuxent River, Maryland		d. STREET ADDRESS 513 SW 8th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Charles		First	Middle	Lost	4. DATE OF DEATH WILLIAMS	Month June	Day 14	Year 1956			
5. SEX Male	6. COLOR OR RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3-24-37	9. AGE (In years last birthday) 19 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Archie Williams		14. MOTHER'S MAIDEN NAME Loureatha Louise Mitchell									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 9-22-55		17. INFORMANT U. S. Naval Records		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO 929.8											
Candidians, if any, which gave rise to immediate cause (a), stating the <u>underlying cause last</u> (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While swimming, enlisted beach, USNAS, Patuxent River, Md.									
20c. TIME OF INJURY Month, Day, Year How 5:15 p. m. June 13 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Enlisted Beach		20f. (City or town) Lexington Park, St. Mary's, Md.		(County)		(State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 1:00 P.M., from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>C. W. Freeby, LT MC USN</u> M.D.											
PHYSICIAN'S NAME (Type) C. W. FREEBY, LT MC USN											
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 6/16/56		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) Gainesville, Florida		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>DB Johnson</u>		ADDRESS Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 6/18/56		24b. REGISTRAR'S SIGNATURE <u>Glen A. Hauser</u>					

1951 - CERTIFICATE OF DEATH
WILLIAM SAGE DEPARTMENT OF HEALTH - BALTIMORE, MD

239

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BUENOS AIRES

9551 C. 1000

RECEIVED
1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6552 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

106539
10. 282

<p>1. PLACE OF DEATH o. COUNTY</p> <p>ST. MARYS MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE MARYLAND b. COUNTY ST. MARYS</p>								
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</p> <p>OAKLEY</p>		<p>c. LENGTH OF STAY IN 1b</p> <p>life</p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</p> <p>OAKLEY</p>								
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</p> <p>RURAL</p>				<p>d. STREET ADDRESS</p> <p>RURAL</p>								
<p>3. NAME OF DECEASED (Type or print)</p> <p>AGNES</p>		<p>First MIDDLE</p> <p>PEARL</p>		<p>LAST</p> <p>WOOD</p>	<p>4. DATE OF DEATH</p> <p>JUNE 16 1956</p>	<p>Month Day Year</p>		<p>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>				
<p>5. SEX</p> <p>FEMALE</p>		<p>6. COLOR OR RACE</p> <p>WHITE</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH</p> <p>JAN. 17, 1903</p>	<p>9. AGE (In years last birthday)</p> <p>53 yrs.</p>		<p>IF UNDER 1 YEAR IF UNDER 24 HRS.</p> <p>Months Days Hours Min.</p>				
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p>HOUSEWIFE</p>			<p>10b. KIND OF BUSINESS OR INDUSTRY</p> <p>DOMESTIC</p>			<p>11. BIRTHPLACE (State or foreign country)</p> <p>MARYLAND</p>			<p>12. CITIZEN OF WHAT COUNTRY?</p> <p>USA</p>			
<p>13. FATHER'S NAME</p> <p>JOHN H. RUSSELL</p>				<p>14. MOTHER'S MAIDEN NAME</p> <p>SARAH F. HAYDEN</p>								
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)</p> <p>NO</p>				<p>16. SOCIAL SECURITY NO.</p> <p>-----</p>			<p>17. INFORMANT</p> <p>THOMAS L. WOOD * OAKLEY, Md.</p>				<p>Address</p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) 976x <u>GUNSHOT WOUND - BRAIN</u> INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE</p>												
<p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</p> <p>(b)</p> <p>DUE TO</p> <p>(c)</p>												
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>											<p>19. WAS AUTOPSY PERFORMED?</p> <p>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> <p>SELF INFILTED GUNSHOT WOUND</p>										
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. JUNE 16 1956</p>		<p>20d. INJURY OCCURRED</p> <p>White Not white</p> <p>at work <input type="checkbox"/> at work <input checked="" type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>-----</p>			<p>20f. (City or town)</p> <p>ST. MARY'S Co. MD</p>		<p>(County) (State)</p>			
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</p> <p>ACTUAL SIGNATURE <i>J. Roy Guther</i> DATE SIGNED <i>June 16, 1956</i></p>												
<p>EXAMINER'S NAME (Type)</p> <p>J. ROY GUYTHER MD</p>		<p>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>										
<p>22a. BURIAL, CREMATION, REMOVAL (Specify)</p> <p>BURIAL</p>		<p>22b. DATE THEREOF</p> <p>6/20/56</p>		<p>22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS</p> <p>SACRED HEART CEMETERY</p>		<p>22d. LOCATION (City, town, or county)</p> <p>BUSHWOOD, Md.</p>				<p>(State)</p>		
<p>23. FUNERAL DIRECTOR'S SIGNATURE</p> <p>G.B. Robinson</p>				<p>24a. REC'D BY REGISTRAR</p> <p>- LEONARDTOWN, Md.</p>		<p>24b. REGISTRAR'S SIGNATURE</p> <p>Glenda L. Hayes</p>						
				<p>DATE</p> <p>6/18/56</p>								

1) DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director or forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files. **2) FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MANHATTAN STATE DEPARTMENT OF HEALTH-BUREAU 18
MEDICAL EXAMINER'S OFFICE OF DEATH

SEARCHED	INDEXED
SERIALIZED	FILED
APR 11 1935	
FBI - NEW YORK	
FEDERAL BUREAU OF INVESTIGATION	
U. S. DEPARTMENT OF JUSTICE	
RECEIVED	
APR 11 1935	
FBI - NEW YORK	
FEDERAL BUREAU OF INVESTIGATION	
U. S. DEPARTMENT OF JUSTICE	

BUREAU U. S.

APR 11 1935

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